Department of Vermont Health Access

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Questions and Answers

Regional Comprehensive Addictions Treatment RFP

03410-110-13

General:

Q- The RFP lists the Intent to Bid date as August 18, 2012, by 4:30 p.m. That day is a Saturday. Is it intended to be on a Saturday?

Answer: No. The RFP Intent to Bid date has been moved from August 18, 2012 to Monday, August 20, 2012, by 4:30 p.m.

Q- Could you describe how the State Healthcare System has approached the Blueprint Healthcare Reform and the idea to create a system or network around the Vermont?

Answer: Any protocol that would be recommended for use would be based on the clinical and scientific consensus of the best practice available. That clinical and scientific consensus is always going to be a moving target and evolving. Typically, the way the State has approached Blueprint Healthcare is by using the best protocol available for diabetes and other chronic conditions. Those are established by the medical and scientific bodies and not by, for example, the Blueprint Central Office, or a State role or function. However, where there is more clinical consensus and best science, we hope that the field will adapt and use those best practices.

Q-The State has predetermined the way that the counties are sectioned out for this proposal. When looking at a map and looking at consumers not having to travel as far, it seems like the way that it is set up by the State is irregular to the natural flow of patients to practices. Is the State married to having the counties set up that way?

Answer: The way that the State has discussed this with the spoke providers, the community prescribers, is that the State is not trying to dictate boundaries. If there is a naturally occurring referral pattern that happens within that community, then the State would respect that. The State is looking to the providers to be identifying the referral patterns, making outreaches, and having those discussions.

Q- Are the *Hubs* supposed to service methadone and clinically complex buprenorphine? Would they be distributed through the OTP with the medication?

Answer: The State is aware that it must work through a payment process for the buprenorphine if it is distributed in the OTP versus the OBOT. We are still working on that. The basic staffing plan for both sets of services is essentially the same.
Q- It sounds like the State is hoping that the data will support buprenorphine or Soboxan as being dispensed for the complex clients in the *Hub*. Is this correct?

Answer: Yes, we support dispensed buprenorphine for the complex clients that would continue to be served at the *Hub*. This is the preferred option as opposed to those people who may initiate treatment in the *Hub* and are then moved out into a *Spoke* or back into a *Spoke* with a primary care provider for ongoing management.

Q- There is some confusion between the difference of prescribed versus dispensed buprenorphine. It seems like there may be some bidders who are operating under different sets of assumptions, due to some information not being figured out entirely. However, some of the assumptions are critically important on how one would put together this RFP in a relatively short timeline. Is it a requirement of the *Hub* that they be providing directly dispensed buprenorphine out of the OTP? Specifically, does the OTP part of the *Hub have* to dispense buprenorphine or is it possible to not dispense it on site but rather at a partner site?

Answer: The State would be interested in looking at the proposal to see what your ability and cost to dispense would be. We are not dictating that the proposal has to operate a certain way. It has to meet federal requirements and provide comprehensive care in the *Hub*. The State recognizes that this is a network and there are partnerships. We envision that different areas may see this differently, but we are open to looking at how you propose to put the pieces together in the best way for your area and your partnership.

Q- Are the clinical and physician groups concluded?

Answer: The physician group has been concluded at this time. The clinical group is suspended until more information can be gathered.

Q- Is the State aware if some pilot sites, such as Chittenden and Rutland, have any protocol that they have put together in terms that would be helpful for this RFP?

Answer: Not at this time.

Q- When looking at the clinical scope, should we be looking at it in terms of both the Blueprint and the whole person (finances, personal situation, current health status, etc.)? Specifically, what is the comprehensiveness of the clinical scope that is being envisioned in addition to the creation of the *Hub*s?

Answer: In addition to the creation of the five *Hubs*, the State is also making new investments directly in the practices where patients are being prescribed buprenorphine. There are just under 200 physicians in the State who prescribe, and they are all in all types of practice settings including: OBGYN, primary care, specialist psychiatry, and

patient centered medical homes, etc. This network is getting clinician and nurse staffing to make the buprenorphine supports more robust than they have been previously in order to create some team based care right at the prescriber level. That program is being planned and timed to sync with the development of the *Hubs*. We are now working with the first two official programs in Rutland and Chittenden for the *Hub* services. The Blueprint infrastructure is contacting all of the area buprenorphine prescribers to gain input on how it would work best for everyone if the State were to deploy additional staff to the practices. We are also interested in how the State could best support the practices.

Q- Would it be more adventitious to be a *Spoke* or a *Hub*?

Answer- The State has heard consistent feedback noting that we need more access to methadone treatment. Don't miss the fact that increasing the access to methadone treatment is a very important part of the *Hub* idea. A lot of people who have gone to a buprenorphine treatment have done so only because they could not get into a methadone program. The State is looking into trying to rebalance the system, while trying to do it in a more planned out way. The State needs both the *Hubs* and the *Spokes*. When the buprenorphine physicians were encouraged to come into the picture several years ago, they didn't have the kind of supports to be able to work with the complex patients that we have today.

Q- How did the State develop the estimated target caseload projections on Page 38?

Answer: We used the best information that we had from history. We know how many people have received methadone, the growth rate in the methadone program, number of patients who have received buprenorphine, and the growth rate in the buprenorphine program. Due to the fact that the buprenorphine program has been able to grow at it's own pace, we used that for our growth trend to anticipate the number of Vermonters who may have opioid dependence and for whom medication assisted treatment would be appropriate. It is just a projection. Then we did a rough estimate of a total case load having about 70% using buprenorphine and only 30% would use methadone. Some clinicians said the split was about 60/40%, others said 70/30%. Our goal was to build the fiscal model in a way that supported the full expansion of services to the clinical population who needs the care.

Q- If you have two partners and neither one participates in primary care, how are these primary care providers going to get engaged into this program? In the proposal, it discusses certain services that cannot be provided by either partner, such as pain management or ongoing primary care itself. What is the State's idea for this?

Answer: One of the overall frames of this project is called Health Homes. The Health Homes were created under the terms of the Affordable Care Act (ACA) designed by the Centers for Medicaid and Medicare services to replicate some of the coordinating and more robust functions of Patient Centered Medical Homes, as opposed to primary care as usually. It is also to apply those coordination health promotion services to individuals who have a chronic condition and are at risk of an additional chronic

condition. The legislation specifically names chronic conditions as including mental health disorders and addiction disorders. What the State is asking for is a *Hub*, not a traditional methadone program. The *Hub* needs to be able to provide additional Health Home Services, which are designed to support coordination and linkage across all of the domains of care that a person may need. It does not mean that the *Hub* will necessarily provide the service directly, but that the *Hub* and *Spoke* staff will both have the kinds of relationships to be able to secure and coordinate primary care on behalf of the patient. The State is also looking at the *Hubs* to meet a set of standards that are under development that are very similar to the Patient Centered Medical Homes' standards, but they are standards for specialists. These standards all relate within the dimensions of being able to coordinate care across multiple types of providers, which we are looking to enhance. The underlying fiscal model for supporting the *Hub* staffing, as well as the expanding of caseloads and services, is based on the idea that we are actually paying more for uncoordinated care in the current system. Instead, we are looking to shift the investment rather than of buying it reactively. If we invested in these Health Homes Services in both the *Hubs* and *Spokes*, we would actually be able to have a better health and addictions outcome for this population. We are also likely to have fewer of some of the higher types of utilization that reflect uncoordinated care.

Q- If people are partnering together to submit a response, how should the paperwork be filled out? Do we need multiple copies, or just an identified lead bidder? Who should be listed on the Letter of Intent?

Answer: We are looking for one proposal. Within this proposal, you are required to describe the collaborating organizations, their relative roles, and the agreement among them to the extent that it exists at the time of proposal submittal. There will only be one agreement developed. You do not need to describe all of the proposed organizational arrangements for the Letter of Intent. There should be one letter per partnership. This letter should mention that there is a plan to have a partnership, and the mentioned partnership should be reflected in the upcoming proposal. If selected, the proposal will result in one contract to support the partnership. If there is more than one organization involved, the organizations would have to decide who would become the fiscal agent for the agreement. The particulars and specifics of the partnership should be clear to the State at the time that the proposal is submitted.

Q- Is a *Hub* a geographic entity, or a concept of services? Does it have to be one site? Newport and St. Johnsbury are going to be a *Hub* but two locations, so can it be a virtual *Hub*?

Answer: The State has not spoken to this. It has not been determined that the *Hub* has to be one or the other. Please make sure to describe how you would provide the services that are responsive to the RFP. It is more about the area of people that the *Hub* can serve versus a structure.

Q- How do we identify who or what holds the OTP license?

Answer: All participants must hold a license. For example, partners must both be licensed.

Q- Is it assumed here that all methadone services in the State will become part of a *Hub*? Will there be such a thing as methadone paid for by the State outside of a *Hub*?

Answer: We envision this as building on our existing service system and augmenting that. That was the assumption that we made when designing this.

Q- Does this proposal have to be submitted electronically or by mail?

Answer: It can be either. Please refer to Page 7, Section 1.7.8.2 for specific instructions on proposal submittal. It does need to be in PDF format if it is sent electronically.

Q- Is there a plan for commercial insurance?

Answer: If you have agreements with commercial insurance, we don't envision them changing. We haven't been in conversation with commercial insurance regarding this. You are free to continue to bill other sources as usual. If we see a volume that makes sense, we can make an approach to the commercial insurers to help support the cost of *Spokes* or to support the cost of *Hubs* in collaboration with us.

Standard Core Processes:

Q- In the proposal, it refers to an algorithm for assessing which treatment a patient is best suited for. My understanding is that the doctor's workgroup is supposed to be working on that. Are they the ones who are going to be developing it for standardization purposes? If so, has it been developed?

Answer: On Page 33 of the RFP, under examples of standard *patient care protocols* it states, "An algorithm to determine whether medication assisted therapy for opioid dependence is clinically appropriate and if so, whether buprenorphine or methadone is indicated". If a program has an algorithm that you are already using, it would be important to describe that in your proposal. If you are anticipating that you would utilize tools that were developed as part of this process, then you would also want to note that.

Q- On Page 33, under "Examples of standard *patient care protocols*", there is a mention of shared decision making. What does that mean?

Answer: Shared decision making is the medical term of art that is used to describe patient participation in decisions about treatment and service planning. This is fundamentally important to the success of this work. *SAMHSA* has published best practices, and that is where the State started their rules that have been promulgated for buprenorphine. Specifically, the state referenced *SAMHSA:* Treatment Improvement

Protocol Tip 40, "Clinical Guidelines for the Use of Buprenorphine and the Treatment of Opioid Addiction"*. As the State develops the Medication Assisted Therapy (MAT) rules that are published by the Health Department, it has used SAMHSA's book as the foundation for the work that has been done. The State uses standards that are developed broadly by the field of Substance Abuse Treatment and that are the consensus of the experts.

* McNicholas, Laura. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 2004. Print.

Q- Is there the sense that the *Hub* and *Spokes* will together eventually be using an identical tool or will there be some sort of autonomy or semi-autonomy in the *Hubs* around describing who belongs with buprenorphine or who belongs with methadone? Will it differ from region to region? There are no federal best practices on this matter, so it would be nice to know what DVHA thinks about this.

Answer: We are in the process and finalizing the process of a patient scoring algorithm where we can look at and separate the system from the application of the treatment system. There will always be a level of individual practitioner decision making in order to try to set some kind of a reasonable set of medically established guidelines that make the most sense based on standard protocol. Although there are exceptions to every protocol, the State will determine which processes stay uniform throughout; however, there will be flexibility for local interpretation.

Q- How are patients going to be assessed at a *Hub* to determine if they would be better served dispensed buprenorphine over methadone? Normally, if it were OBOT, the algorithm would be referred out to the spoke. This will challenge the criteria between complex and not as complex patients. As a clinician, I would consider most of my patients to be complex- increasingly so. Is it the State's goal to operationalize that?

Answer: This should be determined by the algorithm that each bidder is responsible for creating. The State does want to operationalize over time and with all of the providers. We think about people who are clinically complex who have had multiple failed trials, multiple acute care episodes, maybe needing a lot of support services, etc. What we are trying to do with this initiative is to have the decision about what level of support and which occasion to use what drug to be clinically driven- as opposed to dictated by a regulatory structure or by what is available. We are trying to work with the current methadone providers now to enhance their clinics' ability to serve people who are presenting so that we are able to get a more accurate picture of what those needs are. We would prefer to know the actual needs versus having clinics feel pressed by artificially setting caps.

Q- Can any person get a buprenorphine treatment just by going to their doctor? Or would they have to be referred to a *Hub*?

Answer: Yes, if your doctor has the XDEA license to administer the drug. Currently, there are close 3,000 Vermonters who are getting buprenorphine prescribed by outside physicians of all types. We would expect that many of those physicians would

want to continue providing that care. For the new practices coming into this program, we ideally would have more common assessment protocols being used by the buprenorphine physicians and the *Hubs* so that these types of decisions are made with more clinical consistency. The *Hub* should have relationships with area buprenorphine prescribers to be able to refer and discuss back and forth.

Q- Sometimes our clients seem to be moving targets. They can alter from complex to not on a day to day basis. Depending on the area that you are in and the expertise of the different *Spokes*, the *Spokes* are going to be able to handle different levels of complexity. Despite the nature of how methadone is already set up, you would have more structure in the whole process. If they were established in a spoke and became more complex, then could they be referred that way?

Answer: Yes. We are visualizing a network that we are trying to achieve between *Hub* and *Spoke* so that, just like with other healthcare conditions, a patient should have a medical 'home' that would refer them to a specialist for a period of time, but then the patient would always return to their medical home. We are also making some assumptions that a lot of these patients have other medical complex conditions. While they may be getting this medication, they may be getting other medications or needing other medications whether for mental or physical health; this ensured that coordination with the spoke becomes really important, but it doesn't mean that the patient has to stay in one place to receive their full treatment. There could be movement back and forth like with other medical issues.

Q- If somebody is stabilized on buprenorphine, would they continue at a *Hub*?

Answer: It has more to do with the idea of the complex client. If they have a need for a lot of case coordination with other social service issues, they very well could remain in the *Hub*. If they are in maintenance, everything is stabilized, and the criteria shows that they could move out in to a spoke and be managed there, then that is an option as well.

Q- Are there protocols that the State feels are best practice that they would like to see employed in other programs.

Answer: Those best practice protocols are being developed along the same time as the State is working on this program. They are not fully formed or published best practices or standards. We do have the MAT rule, which is on the health department's website: http://healthvermont.gov/regs/documents/opioid_dependence_rule.pdf

Q- Often, a number of our patients are in need of more intensive services, and are referred to an intensive outpatient program. How is the IOP absorbed for this?

Answer: The RFP is assuming that you will be performing the level of services that are typically associated with methadone and buprenorphine. The range of care may be more intensive at first but adjust into lesser services over time for some complex patients. If you make a referral to a residential program, it is just going to operate the

same way that it normally works. If you currently operate an IOP and you make a referral, it will work the same way. If you currently do not operate an IOP, this is not assuming funds to start up a new specialty IOP program.
Q- Has there been a contract implemented for the Covisent software that allows everyone to communicate?

Answer: Covisent provides the Blueprint with the Central Clinical Registry, and it also does activity tracking for the State under a variety of initiatives including the Community Health Teams and Support and Services at Home (SASH). The State, along with Covisent and subject matter experts from Vermont, is planning to design a measure set to reflect the core clinical things that occur in the provision of addictions treatment and specifically methadone and/or buprenorphine. It will be a spare set of the basic function. That registry will be available for use as soon as it is built; the target date is January 1, 2013. There will also be an activity tracker in the registry that will track the CMS Health Home Services that are described in the RFP. The clinical registry and/or the account tracker are not a communication tool. The State is aware that there is much that could be done in order to support the provision of necessary clinical information across organizations and between providers. The Blueprint for Health program is piloting a communications tool or program called Provider Link to do that. We are not sure yet how well it works or if it answers the kinds of questions that it must, because it has not completed.

Because we are talking about Protected Health Information (PHI), and especially because we are talking specifically about addictions and mental health treatment, even higher levels of privacy standards are held. We are in early stages of developing the capacity to actually share substance abuse treatment information across treatment providers. Telephone, fax, and email will still be required to uphold the same confidentiality rules and permissions the State currently does.

Q- When referring to protocols, how do you manage someone who is coming up with a preference of Soboxon? We see a lot of patients who are buprenorphine dependent, making it their first drug of choice and the only opioid that they use. If a person's main drug of abuse is buprenorphine and they present for treatment, how would we go about handling that?

Answers: This would depend on current protocols and procedures. The State actively encourages clinical groups to discuss current trends and work together.

Payment:

Q- There is some confusion around the funding roles. It definitely speaks more to methadone than buprenorphine. When it says to provide a *Hub* staffing scale model for 400 patients, is the State looking to do case rate on all forms of medication assisted treatment? Or is it looking to eliminate drawdown funding for clinical services? It seems unclear of how to put together the payment provisions.

Answer: The State is envisioning a bundled rate that will include all of the services in the *Hub* that would be built around methadone and also a subset of clinically complex buprenorphine patients.

Q- In regard to the bundled rate that the State has referred to, does that include the cost of medication?

Answer: The State needs to decide the medication cost of the buprenorphine. We have yet top determine whether or not it makes more sense for it to be included within the bundle or outside of the bundle. It will depend on whether or not the *Hub* wants to be able to bill that separately or together, and what kind of reimbursement rates it could accept. We have built this to be a cost neutral model, so we wouldn't pay more for the medication than what Medicaid currently pays. The rate of the cost estimate that you see developed in the proposal does not include the cost for buprenorphine.

Q- Does the bundled rate include urine drug screens, lab work, doctor time, etc?

Answer: Yes, it would cover everything except the buprenorphine.

Q- It has been noticed that there has not been any built in psychiatry time. Would that be billed out separately?

Answer: There is psychiatry time built in. Within the *Hub* Staffing Scale Model on Page 38, it shows that there is a 20% FTE Consulting Psychiatry section.

Q- Does the Overhead section of the *Hub* Staffing Scale Model on Page 38 include things like urine drug screens and lab work?

Answer: Yes.

Q- Are the fees from this service absorbed by the State?

Answer: The State is absorbing the use of the clinical registry and the activity tracker. The concept is that you will be able to do a direct data entry or we will have to have an interface developed, just as we do for the patient centers at medical homes, into the clinical registry.

Q- If we add more in house services, at what point in time would our funding change? Are we restricted to the monies that we get on an annual basis? For example, if we were to provide primary care, a nurse practitioner who sees clients for that purpose, or an IOP in house, how would that affect our current rate of funding?

Answer: The basic proposal is to first try to create a bundled complete payment for the *Hub* service itself. This is what the scale model is designed around. We have not proposed to shut off or change people's access to other services outside of that. As with

any program, you have the opportunity to develop services that you can find ways to fiscally support and manage. The State would like to remind bidders that the funding that we have available is specific to this RFP. If there are additional components that a bidder wants to include, it will be looked at; however, it is not assumed that the State will accept other items that are outside of the scope.

Q- If we have a current bundled rate for methadone treatment, would we be able to use it for this RFP?

Answer: You may submit your current bundled rate for methadone; however, it will include some additional things. Please reference the model that is included on Page 38.

Q- If we are doing this as a partnership, is it that together we get reimbursed and work with each other, or will we be expected to bill the State per patient?

Answer: We will create a single rate for this collection of services. Selected proposals will either be single organizations or partnerships of organizations that will have an arrangement for how they will successfully provide these kinds of services.

Q- Will the single rate mentioned above be a result of the bids?

Answer: Yes.

Q- Could you clarify the how the payment will work with this model if it is a bundled rate? Is it a rate per patient in a given month or stage? Should the buprenorphine bundle look similar to the methadone bundle?

Answer: Yes, it is just like methadone. We are thinking of a single rate that will include all services. The bundle of services in the *Hub* where they are providing a more intensive service, they would be the same. The difference will be the medication. In a spoke, we are providing the utility of the case manager and clinician, but they are a traditional fee for service.

Q- Do you have to have the capacity as a *Hub* to bill third party payers? Would you have to keep the *Hub* open to third party payers?

Answer: If you are looking to receive funds other from Vermont Medicaid, you would have to be able to have the capacity. If you do not want to be a provider for third party payers, that decision is with each Business Associate. The State has no input on that decision. This RFP is purely a Medicaid bid.

Q- For example, if the Howard Center is a *Hub*, they are going to have a bundled rate for OBOT and OTP service. If, after the bundled rate ends, the client needs additional services, could the Howard Center then just refer to itself as a Spoke in their outpatient services?

Answer: Yes, if the patient is no longer in Medicaid Assisted Treatment. We are hoping that you will think about the needs of the patient, and not just about trying to meet the structure of previously existing programs. We want to move toward a more flexible model to get the patient to a clinically sound outcome where they can move on from needing treatment.

Q- In regards to the current uninsured clients that we serve right now, we serve them because we know that we have a grant from ADAP to make that happen. Now they are still going to come, and we are not sure if we are going to get that grant again. How do we figure that into our budget so that we don't have to absorb the cost of those services? If we don't know what is going to happen with that money, it will be difficult to bid it out.

Answer: We have a principle amount including all of the resources that ADAP currently spends in the methadone program to help fund these *Hubs*; DVHA is adding additional resources to that in order to help support the growth and case load. We have not changed anything fundamental about that. In your proposal, provide a description of your uninsured, Medicare, and so on. If you are a selected bidder, we can move into a contract negotiation to further work these details out.

Q- Is there anything to restrict us from charging self pay?

Answer: If they have Medicaid, you are not allowed to charge anything. If they are uninsured or do not have Medicaid, you may charge them as you normally would for payment. This RFP is for Medicaid only.

Staffing:

Q- The State said that it plans to increase staffing to practices that prescribe Soboxin independently. Is this anticipated to eliminate backlog that we face when we are unable to move patients that are not challenging out of the *Hub* into the *Spokes*? Is that the goal?

Answer: Yes. After a large amount of prescribers left the State, the remaining ones they told us that the way to open up or improve access in order for them to take on patients is that they need clinical, case management, and counselor support. As part of the Blueprint key, we will be deploying a case manager, nurse case manager, and a clinician for every one hundred patients. The State is working through the Blueprint to make sure that they reach out to the community providers to assess how to best utilize those resources. That will help a medical practice be able to do some of the social work and community connection functions that were referred to in the question. Part of what our general practices were saying to us is that in order to treat these clients, they need more team based care. They also don't feel like the current payment mechanisms don't support their ability to provide care to complex patients. The State is investing in a staffing infrastructure to be in place and paid for by the Department of Vermont Health Access or

the Medicaid Program; this will make it essentially free for the buprenorphine provider and to their patients.

Q. If a person were doing care management, could they work for 3 practices if each practice had 33 $^{1/3}$ patients?

Answer: Yes, staff will be deployed to the practices just as they are now with the Community Health Team and their participating practices. It works pretty well, particularly if you do it in collaboration with those practices and plan it locally.

Q- Could the above mentioned staff person be connected to a drug and alcohol program? If so, would they be employed by the practice?

Answer- Yes. You are required to bring forth and describe how you are going to do that for your area, and show us the collaboration and agreement of your participating physicians.

Q- On Page 38, Section 2, there is a *Hub Staffing Scale Model* for 400 patients. Is this a template that we are allowed to deviate from?

Answer: Yes. It is a template that we have based the financial model for this RFP on. If you are deviating from the fiscal model, the State either needs to find more savings somewhere else in order to support that expense, or it could be under budget. There is a world of difference between models and real life. This model in particular has been looked over by multiple staff members, and it is a framework. Please build your proposal with what you believe is the most sensible, manageable concept. Our idea is that we would be able to have more complete access statewide to methadone and practices would be paid based on the number of individuals whom they are clinically serving who are found clinically appropriate to have that service.

Q- How is the State going to support case managers that will be working with buprenorphine? Are they attached to the primary care practices or the *Hub*?

Answer: We are working on the infrastructure of the Blueprint for Health, which currently has about 90 primary care practices Statewide that service around 400,000 Vermonters who are part of Patient Centered Medical Homes enrolled in the Blueprint program. All of those practices share a Community Health Team that is paid for, in this case, by the commercial payers and the public payers. That Community Health Team staff is deployed to the primary care practices depending upon the size of that practice and the needs of the community. The State is attaching this additional resource onto this infrastructure to organize the nurse and clinician staffing for the buprenorphine providers. The Blueprint directors and Community Health Team staff are working with the area buprenorphine providers to organize arrangements for how to deploy additional staff resources. It is essentially the same as how the Community Health Teams are working with the primary care practices; additional spoke staffing will be working with the buprenorphine providers and will be able to help coordinate services with the *Hubs*.

Other:

Q- Is there a role for prescribed buprenorphine in the *Hub*, rather than dispensed buprenorphine? Our vision was not one of dispensed buprenorphine in a collaborative agreement, but of dispensed methadone and structured, prescribed buprenorphine in the way that we are currently doing. Could you do both?

Answer: We are looking into that, and it is under design. It is a matter of interaction between the regulatory framework and our billing and reimbursement. The State's intention is to be able to offer both types of medication in the same robust service package of the *Hub*. We are actively working with the Howard Center in order to figure out how to do that within the reimbursement and regulatory frameworks that we have. We are looking for bidders to assume that it will all come together; however, the specific costs of the buprenorphine will be adjusted to work accordingly with the successful bidders depending on what the final answer is. We need to do what we can and cannot in order to make it work and to meet all of the guidelines.

Q- Is there anything to prevent a *Hub* from both prescribing and distributing? In other words, can a doctor prescribe under his own license or under the OBT license?

Answer: It is difficult for the State to interpret the OTP regulatory framework at this current point in time in this context. As you are thinking about your partnerships and what the potential is for working it through both clinically and programmatically, keep in mind that what we are trying to drive toward is making the decision about which medication to use and which level of support to use. We want it to be a clinical decision and not one that has been based on the conventions that have historically been forced into.

Q- My understanding is that if the *Hub* comes under the umbrella of an OTP, then the medication has to be given at the clinic and observed, unless they are adhering to a take home regiment.

Answer: The State cannot comment on non State regulations at this time. However, we are envisioning environments where there are multiple organizations that may have different licenses and so forth that may be collaborating in this. We hope that this will open up some opportunities that may be different. We have been looking to see if there are examples, either in the region or nationally, that have programs with both an OTP and an OBT license. There are probably ways that that could be arranged locally. As bidders are thinking about this in terms of their clinical proposal, the State wants to work out any regulatory barriers or anything that poses a barrier to what works best. Bidders should be thinking about what they are proposing from the best clinical care aspect.

Q- On Page 34, it speaks to agreements. Is there an expectation that *Hubs* will have to have agreements, MOUs, or some other form of understanding with community resources?

Answer: It will work much better if you have those agreements in place. You will be much more able to do the required care. One of the Health Homes Services that you will be providing is Comprehensive Care Coordination, which is not only for individual care, but also for setting up the protocols and systems that support that care across a population that you are helping to manage and across organizations.

Q- Part of the problem in our area is that patients can't get primary care providers because they either don't take Medicaid or they don't take new patients. It has been very hard to connect patients to primary care. What is your input on this?

Answer: These patients may be particularly difficult to connect to a primary care provider, which is part of why we are trying to make investments in these staff for primary care in both the Blueprint, which has additional payments that go to participating primary care practices, and the support of the Community Health Teams. Unfortunately, we will probably not fix all of the access issues with this initiative, but we hope that it will help.

Q- Is there any sense that, with the Health Care Reform, this would encompass private insurers in Vermont, or is it Medicaid clients only? Will uninsured clients also have access to the *Hub* and *Spoke* services as well?

Answer: Yes, uninsured clients should continue to have access to *Hub* and *Spoke* services. Obviously, it is an important intervention to get people stable on insurance for a lot of reasons. We are interested in learning about the extent to which there is a commercial clientele whose other health insurance products support these services and who are open to making approaches to those other commercial payers. This is just as we have in the Blueprint for the Patient Centered Medical Homes and the Community Health Team for purposes of the development of this model. The Department of Vermont Health Access, Vermont Medicaid, is such by and large the major player that we have modeled this on Medicaid beneficiaries, Medicaid costs, and Medicaid resources to fund it.

Q- On Page 13, number 9, *Requirement to Have a Single Audit*, a single audit is a non-profit requirement that means something different in the profit world. Our company uses a Generally Accepted Accounting Principles (GAAP) audit; is this acceptable?

Answer: This comes from our standard template Attachment C, Customary Provisions for Contracts and Grants. These terms are part of our agreements, and any alterations to the documents can be discussed once an agreement is offered as a result of the submitted proposal. If you currently have a contract with the State, you have probably already signed Attachment C as is.

Q- In the Business Associate Agreement, Page18, Section 16.1, it refers to 45 CFR, but aren't we referring to 42 CFR?

Answer: These are Codes of Federal Regulations that are in current agreements. This one in particular is a standard document that accompanies each agreement regarding the requirement of safeguards that each Business Associate that results from this RFP must use in order to protect State PHI. Each Business Associate is required to identify in writing all of the safeguards that it uses upon request from the State.

Q- On Page 21, Section 10, *Intellectual Property/Work Product Ownership,* are current data, technical information, materials gathered, originated, developed, prepared or obtained *before* the contract subject to becoming State property if it is utilized for work on this agreement?

Answer: It is specific into the agreement that you enter into as a result of this RFP. If your proposal results in an agreement, you may review the specifics of the agreement prior to signing it.

Q- On Page 34, under the bulleted numbers, the RFP states, "*The University of Vermont Child Health Improvement Program (VCHIP) team currently under contract with the* Blueprint for Health *will provide an independent initial evaluation of the Hub's capacity to meet the Specialty Practice Standards… at subsequent intervals, the Hub will be reevaluated and a portion of payment for services will be based on the program's rating on the Specialty Practice Standards".* Would you be able to explain this in more detail?

Answer: The National Committee on Quality Assurance is developing Specialty Practice Recognition Standards, just as they have standards for Patient Centered Medical Homes. In the case of specialists, they drive right to the heart of the Health Homes and the ability to coordinate and collaborate with various organizations on behalf of people's care. We want the *Hubs* to be able to meet these standards and to participate in the surveys. We will provide the evaluation of the surveys through the VCHIP, just as we do for the Patient Centered Medical Homes. You will be surveyed for a baseline and then surveyed again at regular intervals; we would want to see improvement from that original baseline. These standards are still in development, so we cannot provide the scoring algorithm. Instead, we will start with a baseline. We are looking for a commitment from our bidders to participate in the Specialty Practice Recognition Standards development. We are moving to look at the addiction treatment centers to increasingly move into the medical world, because that is the expectation with Health Care Reform. There is articulated parody with mental health and substance abuse, and the increasing assumption that these services are specialty care services. It is going to mean that we are all moving in a changing direction. Because of the medical nature of these particular services to begin with, this is the place where it is most essential to start.